Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4880AGC	A. BUILDING _____ B. WING _____	C 05/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF HENDERSON	1555 WEST HORIZON RIDGE PARKWAY HENDERSON, NV 89012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of complaint survey conducted on your facility from 4/20/10 to 5/5/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 105 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 57. One discharged resident file was reviewed. Complaint # NV00022723 was substantiated. See TAGs Y623 and Y853. The following deficiencies were identified:	Y 000		
Y 623 SS=D	449.2702(4)(d) Admission Policy NAC 449.2702 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (d) Requires skilled nursing or other medical supervision on a 24-hour basis. This Regulation is not met as evidenced by:	Y 623		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 623	Continued From page 1 Based on record review from 4/20/10 to 5/5/10, the facility admitted a resident that required skilled nursing care or other medical supervision (Resident #1). Severity :2 Scope: 1	Y 623		
Y 853 SS=D	449.274(3)(a) Medical Care / Records NAC 449.274 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. the record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered. This record must accompany the resident if he is transferred to another facility. This Regulation is not met as evidenced by: Based on interview and record review on 4/28.10, the facility failed to ensure there was a written record of the resident's accident or injury (Resident #1). Severity: 2 Scope: 1	Y 853		